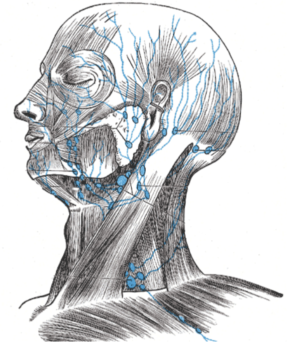
Integrative Bodyworks LLC
Karen Urwin LMT, MMP



Clients Name: ___________________________

Claim #: ________________________________

D.O.L.: _________________________________

D.O.B.: _________________________________

Please complete all form prior to first appointment.

Appointment time: ______________________________

_____ Welcome Letter

_____ Insurance & Attorney Information

_____ Prescription and Diagnosis Codes from doctor

_____ Signature on File

_____ Fees and Policy

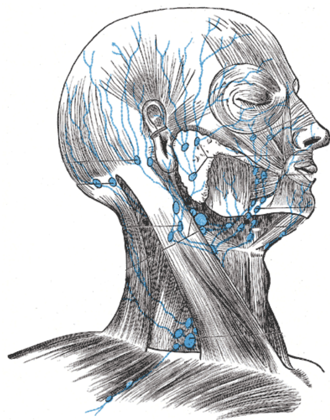
_____ Contractual Guarantee of Payment

_____ Health History

_____ Accident Questionnaire

_____ HIPPA

If you have any question, please feel to contact Karen during regular business hours at 303-523-0773 or after hours via email at info@ibdenver.com.



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It is always recommend that three MLD sessions are preformed. This allows the body to detox, rejuvenate while stimulating the immune system. The subtle work has profound effect on the body.

If you need to reschedule or cancel your appointment, please give at least **48 hours before the appointment to avoid the "missed appointment" fee.** You will receive a confirmation reminder via text/ email 48 hours prior to your appointment. If you miss this appointment it could be weeks before another would be available, and you would be responsible for the full fee of the service.

Here is information regarding your appointments:

Karen works from home that is located in the Park Hill neighborhood in east Denver, between Quebec and Monaco just North of Martin Luther King Blvd. The address is **3240 Newport Street, Denver, CO 80207.**

Karen accepts phone calls and text **Monday-Friday, 8:00AM-6:00PM**. If you need to contact her outside of business hours, please do so through her email at info@ibdenver.com**.**

If you arrive early to your appointment, please wait until your appointment time to ring the bell. Karen has back to back appointments and is not able to answer to door other than at times other than your scheduled appointment. If you find that you will be late, you can text her at 303-523-0773 to let her know your estimated arrival time.

If you are not able to keep your appointment, experience has shown us that it could be weeks before another appointment would be available. For those who cancel on a regular basis you might be asked to prepay for session and at some point the prepaid sessions will no longer be refundable. If this is the situation, Karen will discuss this with you prior to this policy being instated or services could be terminated permanently.

If you have active cold or flu virus, **please call at least 48 hours to reschedule.** Karen is very careful not to expose herself or the treatment room to illness which might inadvertently transmit to someone. Stay home, care for yourself, and see your primary physician if needed.

If you are recovering from the cold or flu, wait until you are **at least 90% through the illness before coming in for a session.** Your lymphatic system is already overwhelmed from the illness and to have a session with an active illness could potentially overwhelm your system even more causing you to have a relapse. If you arrive with an active cold, you will be turned away and full payment will be expected.

If you have had an inoculation or cortisone injections, please call and discuss this with Karen before your appointment as it can be contraindicated and a certain amount of time need to pass before a session is recommended.

Karen takes and return calls between **8:00AM and 6:00PM** Monday-Friday. If you have **questions regarding your appointmen**t, please feel free to call at 303-523-0773 or via info@ibdenver.com

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Insurance Authorization

Date: _________________ Date of Accident: ___________________

Name: ____________________________________D.O.B.: ______________________

Hm Ph. __________________ Wk Ph. ___________________ Cell Ph.: _________________

Insurance Comp.: _____________________________ Claim #: _______________________

Address: ___________________________ City: _______________ St: ____ Zip: __________

Ph: _________________________ Ext. ________ Adjustors Name: ____________________

Do you have Med Pay? YES NO Referred By: _____________________________

Do you have a prescription for massage therapy or lymphatic drainage? YES NO
Prescription Date: __________________ Date of last visit by referring doctor? _______

Name of Insured Party: ____

Employer:_______________________________ Employer Phone #: ___________________

Law Firms Name: ____

Attorney's Name: ________________________________ Ph #: ________________________

Address: ________________________________ City: _______________ St: ____ Zip: ___

Integrative Bodyworks LLC
Karen Urwin LMT, MMP

Signature on File

Patient's Name: ____________________________________ Date of Birth: ____________________________

Insurance Company: ____

Accident date: ____________________________ Claim Number: _____________________________________

I authorize **Integrative Bodyworks LLC** to release to any insurance company, adjuster, attorney or health care provider involved in this case, medical or other information needed to process this or any related claim.

Patient's Signature ____ Date ________________
(Note to patient: It is common for insurance companies, attorneys and health care provider to ask massage therapist for a description of the procedures they deliver or other information I may have on your condition and treatment. Your signature above gives me the right to provide such information. I will give such information only to your insurance company; attorney or other heath care provider working on your case and only when they request it to help the processing of your claim.

****

I authorize payment of insurance benefits to **Integrative Bodyworks LLC C/O Karen Urwin LMT, MMP**

Policyholder's Signature ____ Date ___________________
(Note to policyholder: Your signature above means that your insurance company will pay claims for the clinic service directly to the clinic, not you. If you want insurance payment to go to you, the clinic must be paid at the time of service and you must file and collect the insurance claim yourself.)

If current policy prohibits direct payment to the clinic, then I hereby instruct and direct you to make out the check to **Integrative Bodyworks L.L.C.** and mail it as follows:

Integrative Bodyworks LLC
C/O Karen Urwin LMT, MMP
3240 Newport Street
Denver, CO 80207
Phone 303-523-0773

Policy Holder's Signature ____ Date ______________________
(Note to policyholder. Your signature above means that if your insurance company prohibits direct payment to the clinic, your insurance company will make the check payable to you and you will send them to the clinic.)
****
I authorize a copy of this authorization to be used in place of the original.

Patient's Signature ____Date _______________________

Policy Holder's Signature _____________________________________ Date ________________________
(Policy Holder's Signature is needed only if the policyholder is not the patient.)

(Note to patient and policyholder: Your signature allows me to put the words "Signature on file" on claim forms. If you don't sign this you'll have to sign each form I submit on your behalf.)

Integrative Bodyworks LLC
Karen Urwin LMT, MMP

Fees and Policy

A. Fee for Insurance Billed services are as follows:

97032	Lazer	$25.00 per 15 minute unit
97140	Manual Therapy	$50.00 per 15 minute unit

B. Copying fee are as follows:
$16.50 for the first 10 pages
$0.75 for pages 11-40
$0.50 for pages 41-

C. Payments for services are as follows:
Cash, Checks, Master Card or Visa, HSA, Paypal

I will bill the insurance companies directly under the following conditions:

Auto Insurance: Med Pay, Active Claim, Prior Authorization, Current Prescription, Signed Lien

Insurance payment is anticipated within 30 days. Co-payments/co-insurance amounts are due at the time of service.

All insurance accounts not paid within 90 days from the date of service will be charged interest. Interest rates are 18% annually and are charged at 1.5% monthly. Interest is calculated on the principle amount: interest is not compounded. **Please be aware that you are personally responsible for payments in a timely manner regardless of actions taken by the insurance company.**

D. Patient Agreement
I give my massage therapist permission to consult with my referring health care providers regarding my health and treatment. I authorize the releases of any medical information necessary to process my insurance claim. I am authorizing payment of claims to Integrative Bodyworks LLC for services rendered.

E.Cancellation Policy
A 48 hours notice is required for cancellation or rescheduling or the patient is required to pay $110.00. This fee is not covered by the insurance company and must be paid prior to your texted scheduled appointment.

I have read and understand the above agreement and terms. By signing below I accept the consent to for treatment. I have read the policy stated above and agree to abide by them.

Signature ____ Date ____________________

Integrative Bodyworks LLC
Karen Urwin LMT, MMP

Contractual Guarantee of Payment for Massage/Manual Therapy Services

I hereby authorize and direct you, my attorney, to pay directly to Integrative Bodyworks L.L.C., the total amount owing for therapeutic massage services, provided for injuries arising from the motor vehicle accident on ______________. I hereby authorize my attorney and the involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect my health care provider and their office. I hereby further consent to a lien being filed on my case by said health care provider and their office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated.

I agree never to rescind this document and that any attempt at recession will not be honored by my attorney. I hereby instruct that in the event that another attorney is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment for Health care services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly responsible to said massage therapist(s) or their office for all health care bills, including attached cancellation fees and policy, submitted by them for services rendered to me. Further, this agreement is made solely for said health care provider(s) additional protection and in consideration of their forbearance on payment. I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages.

I specifically request my attorney to acknowledge this letter by signing below and returning it to the office of said health care provider. I have been advised that if my attorney does not wish to cooperate in the protection of the massage therapist's interest, the massage therapist will not await payment, but require me to make payments on a current basis.

Date ___________________ Patient's Signature __________________________________

Patient's Social Security Number ________________________
Driver's License Number ________________________________

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agree to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said massage therapist named above.

Date ___________________ Attorney's Signature _________________________________
Please date, sign, and return:
3240 Newport Street, Denver, CO 80207

THANK YOU

Integrative Bodyworks LLC
Karen Urwin LMT, MMP

Client Information

Client's Name ____ Date ________________________________

Address _________________________________ City _______________________ ST _________ Zip __________

Age ____________ Birthdate ________________ Sex: F M SS# ______________________________

Occupation ______________________________________ Work # _______________________________________

How did you hear about us? ____

Phone Numbers

Best contact phone number: Cell: _______________________ Other: ________________________

In case of an emergency: Name ________________________ Contact #: _____________________ Hm. Wk. Cell.

Insurance Information

Who is responsible for this account? ________________________________ Were you the: Driver or Passenger?

Relationship to Policy holder ________________ Policy or Claim # _______________________________________

Name of insurance company: _____________________ Adjustor's Name: __________________________________

Address: ____Phone #: _________________

Accident Information

Is condition related to an accident? YES NO Date ___________ Type of accident: _Auto _Work _Home _Other

Name of Attorney ____ Phone __________________________________

Address _______________________________ City _____________ State ________ Zip ______________________

Client Condition

Reason for Visits ____

When did symptoms appear? ____________

Rate the severity of your pain on a scale from 1 (least) to 10 (severe pain). _____________

Type of pain: ___Sharp ___Dull ___Throbbing ___Numbness ___Aching ___Shooting ___Burning ___Tingle

___Cramps ___ Stiffness ___ Swelling ___ Spasms ___ Other ________________________________

How often do you have this pain?____

Is it constant or does it come and go? ____

Does it interfere with your ___ Work ___ Sleep ___ Daily Routine ___ Recreation?

Activities or movements that are painful to perform: ____ Sitting ____ Standing ____Walking ____ Bending

____ Lying Down ____ Lifting

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Health History

What treatments have you already received for your condition? ___Medications ___Surgery ___Chiropractic ___Physical Therapy ___Medical Doctor ___Neurologist ___Psychotherapy ___Massage Therapy ___Other

Name and Phone # of Referring Doctor: ____________________

Date of last visit to:

Chiropractor	________	Osteopathic Doctor	________	Orthopedic Care	________
Medical Doctor	________	Neurologist	________	Physical Therapy	________
Psychotherapy	________	Surgery	________	Massage Therapy	________

Please circle to indicate the following: Exercise: ____ None ____ Moderate ____ Daily ____ Heavy

Work Activity: ____ Sitting ____ Standing ____ Light Labor ____ Heavy Labor

Habits: Smoking: Packs/Day ____________ Alcohol: Drinks/Week ____________ Water: Oz./Day ___________

Coffee/Caffeine Drinks: Cups/Day ___________ High Stress Level: Reason____________________

Injuries/Surgeries you have had: Date

Falls ____________________ ____________

Head Injuries ____________________ ____________

Broken Bones ____________________ ____________

Dislocations ____________________ ____________

Surgeries ____________________ ____________

Rate your overall health condition: Excellent Above Average Average Below Average Poor

Please circle to indicate if you have had any of the following:

AIDS/HIV	Brest Lumps	Gout	Migraine Headaches	Pneumonia	Skin Conditions
Alcoholism	Bronchitis	Heart Disease	Multiple Sclerosis	Polio	Tumors, Growths
Anemia	Bulimia	Hepatitis	Osteoporosis	Prosthesis	Tuberculosis
Anorexia	Cancer	Hernia	Pacemaker	Psychiatric Care	Thyroid Problems
Appendicitis	Diabetes	Herniated Disk	Parkinson's Disease	Rheumatoid Arthritis	Ulcers
Arthritis	Emphysema	Herpes	Pinched Nerve	Stroke	Varicose Veins
Asthma	Epilepsy	Kidney Disease		Scoliosis	
Bleeding Disorder	Fractures	Liver Disease			
	Goiter				

Pregnancy

Are you pregnant? NO YES Due date? ____________________

How many children do you have? ________ Ages of Children? _______ _______ _______ _______

Date of last birth: ____________________

Have you had any miscarriages. NO YES When? ____________________

Heart Conditions

___Heart Attack ___Open Heart Surgery ___Heart Diseases ____ Arteriosclerosis ____Congestive Heart Failure

Explain ____________________ Date ______________

Do you have a current illness (cold, flu, sinus infection, etc.) ____________________

All information is confidential. I hereby confirm that all information given is accurate and correct to the best of my knowledge. ____________________ Date ______________

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ACCIDENT QUESTIONNAIRE:

Name: ____

Date of Accident: ____

Location of Accident: ____

QUESTIONS ABOUT THE ACCIDENT CIRCUMSTANCES

Year and Make of the vehicle you were riding in: ______________________________________

Number of other vehicles involved: _________

Year and Make of other vehicle(s): ____

Monetary damage to your vehicle: $_________________________

Monetary damage to other vehicles: $_________________________

Speed of vehicles at impact: Your vehicle: _________ mph Vehicle #2: _________ mph

Vehicle #3 ________ mph

Were you the driver or passenger? Driver____ Passenger____

If passenger, where were you seated? Passenger seat: ______ Rear seat, driver's side:______

Rear seat, passenger side: ______

Were you wearing a seat belt at the time? Yes____ No ____

Was your vehicle moving or stopped? Moving ____ Stopped ____

Did your vehicle strike another vehicle? Yes ____ No ____

Did another vehicle strike yours? Yes____ No ____

Where was your vehicle hit? In the front ____ In the rear ____ Driver's side ____ Passenger's side ___

Describe the impact: ____

____

____

If your vehicle has air bags, did they deploy? Yes ____ No ____

What were the road conditions? Dry ___ Wet ___ Icy ___ Snow packed ___ Other ___

How far did your car move after impact? Car lengths ______ Feet ______

QUESTIONS ABOUT YOUR CIRCUMSTANCES AT IMPACT

Did you see the impact? Yes ____ No ____

If yes, did you brace yourself before impact? Yes ___ No ____

Where were you looking? Forward ____ Upward ____ Down ____ Left ____ Right____

Were you looking in a mirror? Yes ____ No ____ If yes, please describe: _____________

____

____

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Cont…

What was your body position at the time of impact? Neutral ____ Forward ____ Rotated (R/L) ____

Which way were you turning? Left ____ Right ____ Not turning ____

Did you strike another object? Wheel ____ Dash ____ Window ____ Other (*describe)*

____

____

Did you experience any of the following at the time of impact?

Cuts ____ Bruises ____ Abrasions ____ Dislocations ____ Bumps ____

Where: ____

Immediate Dizziness _____ Nausea _____ Vision problems _____ Altered consciousness_____

Immediate head pain _____ Discharge from ears or nose _____

Immediate pain (where): ____

Loss of consciousness (how long): ____

QUESTIONS ABOUT YOUR CIRCUMSTANCES AFTER THE ACCIDENT

Were you able to get out of the vehicle and walk on your own? Yes ____ No ____

Was the car drivable from the scene of the accident? Yes ___ No ____

Did you go to the hospital, home, or return to work? Hospital ____ Home ____ Work ____

If you went to the hospital, did you stay overnight? Yes ____ No ____

If you went to the hospital, were any x-rays taken? Yes ____ No ____

If x-rays were taken, what areas of the body were x-rayed?

____

____

What were you told to do? Use ice ____ Use heat ____ Other ______________________

How did you feel that night? Restless ____ In pain ____ Stiff ____ Sore ____ Fine ____

How did you feel the next day? Better ____ Same ____ Worse ____

Have your complaints kept you from doing anything? Yes ____ No ____

If so, what?

____

____

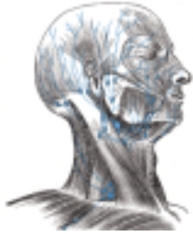
____

Signature ____ Date _________________

Consent for Treatment to a Minor: By my signature below, I hereby authorize ______________________

to administer massage, bodywork or manual therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian ____________________________ Date _____________________



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Privacy Policies Notice

We are dedicated to providing top-quality service. Protecting your privacy is paramount and we have implemented procedures to safeguard your the information.

This notice describes how Protected Health Information (PHI) about you may be used and disclosed and how you can get access to this information. Please Review it Carefully.

Your Personal and Protected Health Information
We may gather personal and health information from you, other health care providers and third party payers. This information is used for treatment, payment and health care operations. The following describes the ways we may use and disclose your Protected Health Information:
* We may provide PHI about you to health care providers, other practice personnel, or third parties who are involved in the provision, management or coordination of your treatment care.
* We may disclose your PHI to any third party you designate in writing.
* We may use or disclose your PHI so that we can collect or make payment for the health care services you receive or are going to receive.
* We may disclose your PHI if we ever sell or transfer our practice.
* We ma contact other providers with updates on your progress or concerns related to treatment.
* We may disclose your PHI if we believe it is necessary to prevent a serious threat to your health and safety or the health and safety of the public.
* We may disclose your PHI to a government agency if we believe you have been a victim of abuse, neglect or domestic violence. We will make this disclosure if it is necessary to prevent serious harm to you or other potential victims, you are unable to agree due to your incapacity, you agree to the disclosure, or required by law.
* We may disclose your PHI to a health oversight agency for activities authorized by law.
* We may disclose your PHI as required by a court or administrative order, or under certain
circumstances in response to a subpoena, discovery request or other legal process.
* We may release your PHI as necessary to comply with laws relating to Workers' Compensation
or similar programs that are established by the law to provide benefits for work-related injuries or illness without regard to fault.
* We may disclose your PHI to a HIPAA certified Business Associate (a person or organization that performs a function or activity on behalf of the practice that involves

the use or disclosure of PHI, such as a billing services company or another practitioner who is involved in your health care).
* Your PHI may be disclosed for military and veterans affairs, for national security and intelligence activities, or for correctional activities.
* We may use or disclose your PHI when required by law.
* We may use your name, address, phone number, e-mail, and your records to contact you with appointment reminder calls, recall postcards, greeting cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

Please note your rights regarding this information:
1. You are entitled to inspect and receive copies of your records.
2. You are entitled make a written request to amend your PHI files or put restrictions on certain uses and disclosure of PHI.
3. We accommodate any reasonable request, yet we retain the right to deny inclusion of amendments or use restrictions of your PHI.
4. You have the right to disagree with the practitioner's refusal of inclusion.
5. You have a right to receive all notices in writing.
6. You have the right to request that we do not disclose your information to specific individuals,
companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.
7. You may complain to us or the Secretary for Health and Human Services if you feel that we have violated your privacy rights. There will be no retaliation for filing a complaint. Written comments should be addressed to our Privacy Officer at our office address or the Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201.

Original Effective Date: April 14, 2003

This notice remains in effect until it is replaced or amended by changes in the law.

Print Name: ____ D.O.B.: ______________

Client's Signature: ___________________________________Date: ________________

Parent/Guardian's Signature: ______________________________Date: ____________